Reply Comments to the American Telemedicine Association's Petition for Reconsideration of the Rural Health Care Support Mechanism Second Report and Order

WC Docket No. 02-60:

I am writing to offer the following reply comments in response to comments submitted regarding the American Telemedicine Association's (ATA) Petition for Reconsideration of the Rural Health Care Support Mechanism. I wish to commend the Commission for seeking comment on this critical issue.

Two concerns

Before offering comments, I wish to raise two concerns regarding the current opportunity to comment. My first concern relates to the timing of the comment period and the possible eclipsing of this comment opportunity by the FCC's Pilot Program for Rural Health Care Funding. On March 9th, the Commission released the Public Notice announcing the deadline for Rural Healthcare Pilot Program applications. Then on March 13th it released the Public Notice seeking comments on the ATA's Petition for Reconsideration of the Rural Health Care Support Mechanism. Within telehealth and rural health interest groups, there was a great deal of notice given to the new pilot project and little-to-none given to this opportunity to comment on an issue critical to many rural communities. For example, on the National Rural Health Association website, the USF Pilot Project was announced but there was no announcement regarding this comment opportunity. I believe the small number of comments received on the ATA Petition for Reconsideration is a reflection of the lack of public awareness regarding the comment opportunity rather than an indication that it is not an issue of importance to rural communities.

Second, I participate, when I'm able, in the USAC monthly outreach conference call. It has become apparent in several recent calls that because of the turnover in rural telemedicine program staff, many current administrators and staff of telehealth programs are not aware that their subsidy will stop when the three year grandfathering period ends. I believe this lack of understanding by many programs that their subsidy will be terminated has also contributed to the small number of comments received and the small number of examples highlighted.

Given that these two issues may have contributed to the limited response to this important comment opportunity, I would encourage the Commission to provide a further opportunity to comment, particularly in light of the ambiguity of the ATA request that I discuss below. Such an opportunity is necessary if the Commission is to fully understand the effect the rural definition change will have on rural communities and the necessity of grandfathering the originally designated rural geographic areas. This opportunity should take place after USAC has notified all sites that will lose their eligibility, of the approaching grandfathering termination.

In addition, I would urge the Commission to consider outreach to key rural health and telehealth interest groups, notifying them of the comment opportunity. Such groups can assist the Commission in ensuring that communities are aware of the comment opportunity, in particular health care facilities in geographic areas that were previously eligible – both those facilities under the 3-year grandfather provision and those facilities that would now participate in telehealth programs if reasonable (i.e., subsidized) telecommunication rates were available.

Reply Comments

Ambiguity of the ATA request: Grandfathering *rural areas/communities* previously deemed rural versus grandfathering *telemedicine sites.*

The ATA, in their petition, has requested that the Commission: "…reconsider the *Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking* with specific regards to the definition of rural and to provide other options for retaining **currently eligible rural communities**[1] for Universal Service subsidies, who are now ineligible due to the new definition".

However, in their petition the ATA then uses three different terms when referring to 'what' or 'who' should be grandfathered (i.e., rural communities, rural sites, and existing health care organizations). This makes it unclear as to exactly what would be grandfathered if the Commission accepts the ATA's recommendations. Specifically, the ATA uses the term "currently eligible rural communities" in their petition's Introduction. Also, in their Summary of Position and Background sections, the ATA appears to build a case for grandfathering **rural communities** (i.e., the geographic areas) that were eligible under the original definition but are now considered ineligible under the new guidelines. However, in the Summary section they also use the term "currently eligible sites" and then refer to a federal program that grandfathered telemedicine sites (i.e., actual programs). In their Argument and Recommendations sections, arguments are made based upon geographic issues, but then the term "existing heath care organizations" is used. Therefore, what is being proposed for grandfathering by the ATA is difficult to determine and this makes a critical difference as will be discussed below.

The lack of clarity regarding this key issue is also reflected in the comments and reply comments submitted. For example, in the comments submitted by Good Samaritan Hospital in Kearney, Nebraska it appears that they are requesting that the Commission grandfather all existing "sites", but whether they are defining "sites" as geographic areas or as "existing health care providers" is not entirely clear in their comments. The University of Virginia Health System requests that the Commission grandfather previously funded "telemedicine sites" as eligible for discounts, noting that investments in telehealth were made based on sustainability calculations that

[1] Emphasis is mine

included the discount. It therefore appears that they are advocating that currently funded telemedicine programs be grandfathered. In contrast, the Northern Sierra Rural Health Network, specifically requests that the Commission continue to grandfather the previously eligible "rural communities" and expand the urban core population threshold to 50,000. The Network also requests that such grandfathering continue until the flaws in the new methodology of designating eligible rural areas are satisfactorily resolved.

Given the ambiguity of the ATA wording, I would urge the Commission, if it chooses to act on the ATA petition at this time, to interpret "rural sites" to be the originally eligible geographic areas, rather than only the individual telemedicine programs located in those geographic areas the initial rural definition. Several entities note that many programs, in good faith, invested in telemedicine networks that may be too expensive to operate if they lose their current subsidy. Most definitely such programs should continue to receive the subsidy. However, grandfathering the originally designated "geographic areas/communities", rather than just the current telemedicine programs, is critical to ensure that the Commission doesn't inadvertently create a digital divide in rural America. That is, many, if not the majority of the initial telemedicine programs, received federal funding to establish their programs. Unfortunately, many other health care facilities in these same geographic areas did not receive outside funding to start telemedicine programs and, because telemedicine technologies were very expensive, such facilities were unable to purchase the technologies on their own. Examples of these include facilities that serve our nation's underserved such as community health centers, public health departments and community mental health centers.

Now however, given the dramatic drop in the cost of technology and the greater awareness of telemedicine and telehealth applications, many of these facilities would participate in telemedicine networks were it not for the high cost of telecommunication services (services no longer eligible to be subsidized given the definition change). For example, here in Hawaii, the community health center on the island of Maui, which was in an area originally designated as rural, but which didn't have a telemedicine program in place when the definition changed, is now ineligible to receive subsidized telecommunication services.

Thus, if the Commission should choose to only grandfather existing telemedicine sites/programs, such as it has done over the past 2 years, rather than grandfather the geographic areas/communities originally considered to be rural (the former being admittedly the easier option), it will promote a digital divide in rural America. Moreover, such a policy would potentially limit health services to our nation's most vulnerable rural populations and deny urban-comparable rates to facilities such as rural public health departments responsible for assuring the public's health.

Rationale for grandfathering initially eligible rural areas/communities and for expanding the urban core population threshold under the new definition to 50,000

Background

In deciding whether to grandfather the initially eligible rural areas, rather than just existing telemedicine programs, and to expand the urban core population threshold of the new definition to 50,000 as suggested by the Northern Sierra Rural Health Network, it is useful to review the Commission's recommendations in the Order and Report of May 1997, the Federal-State Joint Board on Universal Service Recommendations of 1996, and the recommendations of the FCC-established Advisory Committee on Telecommunications and Health Care.

Section 254(h)(1)(A) required the FCC to adopt a definition of "rural area" both to determine the location of health care providers and to determine the "comparable rural areas" needed for use in calculating the subsidy.

If one reviews the rationale for the Joint Board's choice of the MSA / nonMSA (non-metro) classification and the Goldsmith modification to designate rural and urban areas, it was based, in part, on it being an easily administered designation.[2] Under this designation, "rural counties" were defined as "non-metro counties (i.e., counties without an urban cluster of at least 50,000 persons), including parts of counties eligible under the Goldsmith modification. Of more importance though, the Joint Board (and later the Commission) noted that using these definitions was consistent with the congressional intent to adopt "a mechanism that includes *the largest reasonably practicable number of rural health care providers* that, because of their location, are prevented from obtaining telecommunication services at rates available to urban customers".[3] In addition, it was believed than an urban/metro area, having a city of at least 50,000, would have the "market basket" of telemedicine services (i.e., the range of health and public health services, including medical specialties, and health professions educational programs) that the Congress was seeking to make available to rural areas via telecommunication services supported under the Rural Health Care Universal Service Support Mechanism.[4, 5]

In 1997, in setting the mechanism to determine "comparable rural rates", the Commission chose to define the phrase 'nearest large city' to mean: "the city in the

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[2] Recommended Decision – CC Docket No. 96-45, ¶694

[3] Recommended Decision – CC Docket No. 96-45, ¶694 and Report and Order – CC Docket No. 96-45, ¶649.

[4] Recommended Decision – CC Docket No. 96-45, ¶651 and Report and Order – CC Docket No. 96-45, ¶617 & ¶618

[5]The Joint Board's recommendations were informed by the recommendations of the FCC-established Advisory Committee on Telecommunications and Health Care. The Advisory Committee, created in 1996 to advise the FCC and the Joint Board on telemedicine and in particular on the provisions of the 1996 Telecommunications Act relating to rural health care providers, released a report in 1997. The Committee was composed of 38 individuals with expertise in health care, telecommunications and telemedicine.

state with a population of at least 50,000, nearest to the rural health care provider's site…"[6] The Commission stated:

> "Like the Joint Board, we conclude that telecommunication rates in the nearest large city are a reasonable proxy for the 'rates…in urban areas in a State.' We believe that cities with populations of at least 50,000 are large enough that telecommunications rates based on costs would likely reflect the economies of scale and scope that can reduce such rates in densely populated urban areas. We also choose the 50,000 city size because an MSA, as defined by OMB, is based in part on counties with cities having a population of 50,000 or more, and every state has at least one MSA with a city that size."[7]

It is important to note, given the later rule change in 2003, that it was believed in 1997 that cities with populations of at least 50,000 were large enough that their telecommunication rates would reflect the economies of scale and scope of densely populated urban areas, and that a rural provider would likely link to the nearest such city to obtain the health and public health services Congress was seeking to make available to rural communities via a universal support mechanism.[8] In 2003, the Commission released the *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking*, which recognized that their previous rulings on these issues were too restrictive and didn't accurately reflect telecommunication costs nor the availability of needed health services in a city of 50,000. Thus, the Commission's 2003 rule allowed rural health care providers to compare rural rates to urban rates in any city in the state with a population of at least 50,000, as opposed to the nearest city with a population of 50,000. In describing the rationale for this change, the Commission stated:

> "Based on our experience with the program and information in the record, health care providers may not always find the needed expertise in the nearest large city (i.e., a city of at least 50,000). Allowing comparison to rates in any city in the state acknowledges that rural health care providers may communicate with experts in other cities in the state. Such action also should allow rural health care providers to benefit from the lowest rates for services in the State, thereby providing additional support to develop better telemedicine links."[9]

The Commission had found that the largest cities in many states had significantly lower rates and more service options than the nearest city to the health provider with a population of at least 50,000 and believed it was in the interest of the program and rural communities to therefore allow comparison of rural rates to any urban area of the state.

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[6] Report and Order - CC Docket No. 96-45, ¶669.
[7] Report and Order - CC Docket No. 96-45, ¶670.
[8] Report and Order - CC Docket No. 96-45. ¶670 and Recommended Decision – CC Docket No. 96-45, ¶650 and ¶651.
[9] Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, WC Docket No. 02-60 ¶37.

The rationale noted above for the 2003 rule change lends additional support to the necessity of grandfathering in the previously eligible rural areas, not just existing telemedicine sites. Doing so would allow communities with populations between 25,000 – 49,999 to be eligible to receive the subsidy, as well as other smaller communities that may be now ineligible because their location is no longer classified as rural. It also supports the Northern Sierra Rural Health Network recommendation to raise the cap on the urban core population to 50,000. As the Commission noted in 2003, communities with a population of 25,000-49,999, which are now ineligible to receive support, are unlikely to have either access to the lowest telecommunication rates available in densely populated urban areas nor access to the health services that the Congress intended be available to them via telecommunication services supported under the Universal Service Rural Health provision. Moreover, the issues taken into consideration in the 2003 Report and Order appear to contradict the later rationale for capping an urban core at 25,000 given in paragraph 15 of the *Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking* which states that "urban areas above this size (i.e., above 25,000) possess a critical mass of population and facilities"[10].

It is evident in the limited comments submitted that communities over 25,000 but less than 50,000 in areas previously classified as non-MSAs (i.e., rural) possess neither the needed services nor have access to telecommunication rates available in cities of 50,000 or greater. Moreover, the new definition may disproportionately disadvantage western states, where settlement patterns are such that rural communities of 25,000 – 50,000 are often far from the next nearest city of 50,000+ and very far from the a city of 100,000 or more. I know that in my home town of Aberdeen, South Dakota, just an additional 200+ people would put it over the 25,000 urban cap, making the health facilities there ineligible to receive the subsidy. Yet, it is over a four hour drive to an urban area of over 50,000 and health facilities there still pay higher rates than what is available in the nearest city over 50,000. Given the comments submitted, one could conclude that the current mechanism no longer meets the Commission's stated goal and congressional intent of including *the largest reasonably practicable number of rural health care providers that, because of their location, are prevented from obtaining telecommunication services at rates available to urban customers*.

Last, I would note that in some states, although more communities are now eligible under the new definition, the population of these communities is considerably less than the population of the communities that lose their subsidies. For example, in Hawaii the population in all the geographic areas/communities that will lose the subsidy is over 100,000 whereas the population of the geographic areas/communities that are now eligible is less than a quarter of that. Therefore, unless the previously

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[10] Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, WC Docket No. 02-60 ¶15.

eligible geographic areas are grandfathered, tens of thousands of individuals may lose access to needed services in one state alone.

Recommendation and Timeframe:

I would urge the Commission to either defer immediate action on the ATA petition, or as an interim measure, to grandfather the geographic areas originally eligible under the initial definition. The Commission should then seek further comments regarding the issues raised in the comments and reply comments submitted in response to the ATA petition. Doing so would allow current telemedicine programs to continue to receive the subsidy, but as importantly, it would enable rural health care providers who didn't have a telemedicine program in place when the definition changed, to initiate a telemedicine program serving their rural communities and also receive subsidized telecommunication services. (I would urge the Commission to also consider raising the urban core cap of the new definition to 50,000 as suggested by the Northern Sierra Rural Health Network.) I make this request based on:

- the original recommendations and rationale of the FCC's Advisory Committee on Telecommunications and Health Care, the Federal-State Joint Board and the Commission, on how best to define rural for the purposes of determining health care provider eligibility and rural-urban rates comparisons;
- the Commission's experiences noted in the November 2003 *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking;* and
- the Commission's stated intent to use a mechanism that includes the largest reasonably number of health care providers that primarily serve rural residents and are unable to obtain urban-equivalent telecommunication rates.

Time Frame

I believe the Commission may wish to consider how best to establish a time frame for grandfathering. For example, it could grandfather previously eligible geographic areas permanently, as has been suggested by several entities submitting comments. If it chooses not to grandfather geographic areas or sites indefinitely, it could develop a mechanism of review. For example, it could conduct a review every 10 years, after the latest census is available, to determine if a geographic area has substantially exceeded the 50,000 population cap such that it now has access to urban-comparable telecommunication rates and to a broader range of health services. If not, then the 50,000 cap should be waived and the facilities in the area would be allowed to continue to receive the subsidy.

Other rural definition issues

Although this comment opportunity specifically addresses the ATA's petition for reconsideration of the Rural Health Care Support Mechanism, the rural definition change that led to the petition was part of Commissions' broader activity of fine-

tuning the definition of rural for the Rural Health program. Another aspect of fine-tuning the definition of rural in the *Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking* was the new regulation that classified Guam, American Samoa and the Commonwealth of the Northern Marian Islands as "all rural" and as such made them eligible for a 50% discount on advanced telecommunication and information services. This was done in part because the Commissions recognized that these United States territories, although contributing to the Universal Service fund, hadn't received any benefits under the Universal Service Rural Health Care Program. This occurred as the result of a program whose structure, by law, was inappropriate for these small island jurisdictions where there are no communities of 50,000 or more, few specialists and very few subspecialists on-island, only one 4-year institution of higher education and no medical school.

Since the Commission amended its rules in 2005 to provide this support however, less than $4000 has been committed across all three Pacific territories. Given the critical need for telehealth services in the Pacific and given that Congress sought to ensure that all rural health providers had affordable access to modern telecommunication services and specifically directed the Commission to consider health care providers in insular areas when developing support mechanisms, I would urge the Commission to establish a Pacific Initiative as it did for Indian country. It would be helpful if the Commission visited the Pacific as a step to developing a meaningful support mechanism for the Pacific. If the Commission is unable to establish such an initiative, I would recommend that the Commission, at a minimum, set the level of support for advanced telecommunication and information services for rural health providers in all rural states at either 90% or the level of support a jurisdiction receives under the E-Rate program.

Summary

In summary, I recommend that the Commission defer action on the ATA petition until it clarified exactly what the ATA has proposed be grandfathered, and that then, the Commission seek further comments. If however, the Commission chooses to move forward, I recommend the Commission interpret the ATA's petition as requesting the grandfathering of the geographic areas/communities that were initially defined as rural, until such time as it is able to seek further comment. I also recommend that the Commission consider raising the urban core cap to 50,000 as recommended by the Northern Sierra Rural Health Network. Last, I urge the Commission to undertake actions to explore the rural health care telecommunication needs of the Pacific and devise a mechanism that provides affordable access to modern telecommunication services for telehealth purposes in the Pacific territories.

I wish to again commend the Commission for its efforts to continually improve the Universal Service's Rural Health Care Program. Having worked in the Federal Office of Rural Health Policy and the Office for the Advancement of Telehealth,

HRSA when the Universal Service provisions were initially being implemented, it is gratifying to see the Rural Health Care Program continue to grow and serve rural America. I am hopeful that the Commission will seek to address the critical concerns raised in the comments and reply comments submitted. Thank you.

Respectively,

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